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AGENDA

- Background and Risks
- Strategies related to an audit plan
- Reporting best practices
- Potential electronic monitoring tools for risk areas
- Education thoughts
- Case studies
WHAT IS HAPPENING TO PHYSICIANS?

- Increased “HEAT” Activity and Enforcement (Health Care Fraud Prevention and Enforcement Action Team)
- Office of Inspector General audits
- CMS Fraud Prevention System – analytic technology
- Recovery Auditors focusing on billing patterns and approved issues
- MIC – Analyze claims data (Medicaid Integrity Contractors)
- CERT – Audits to measure improper payments (Comprehensive Error Rate Testing)

OTHER CHANGES

- Implementation of the EMR
- Documentation integrity
- Copy/Paste/Cloning
- Meaningful Use attestation and work papers
- Physician Quality Reporting System (PQRS)
CERT - 2010

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Error Rate</th>
<th>No Docum</th>
<th>Insufficient Docum</th>
<th>Medically Unnecessary</th>
<th>Incorrect Coding</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor</td>
<td>43.90%</td>
<td>0.0%</td>
<td>39.5%</td>
<td>57.1%</td>
<td>0.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Hospital Visit-Initial</td>
<td>28.20%</td>
<td>0.6%</td>
<td>38.3%</td>
<td>0.0%</td>
<td>60.8%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Specialist - psych</td>
<td>27.70%</td>
<td>2.8%</td>
<td>74.8%</td>
<td>21.2%</td>
<td>1.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Office Visits New</td>
<td>24.00%</td>
<td>0.7%</td>
<td>30.5%</td>
<td>2.1%</td>
<td>64.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Lab Tests</td>
<td>23.30%</td>
<td>0.3%</td>
<td>21.6%</td>
<td>0.0%</td>
<td>78.0%</td>
<td>0.1%</td>
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<tr>
<td>Nursing home</td>
<td>21.70%</td>
<td>3.8%</td>
<td>51.6%</td>
<td>0.4%</td>
<td>44.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Hospital Visits-Sub</td>
<td>20.50%</td>
<td>1.4%</td>
<td>62.8%</td>
<td>0.0%</td>
<td>35.8%</td>
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<td>Consultations</td>
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<td>Chemo</td>
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<td>4.6%</td>
<td>0.3%</td>
<td>0.0%</td>
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<tr>
<td>Minor Proc</td>
<td>18.10%</td>
<td>1.7%</td>
<td>82.8%</td>
<td>12.4%</td>
<td>2.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Echo/US</td>
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<td>0.0%</td>
<td>52.2%</td>
<td>47.1%</td>
<td>0.7%</td>
<td>0.0%</td>
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<tr>
<td>Ad Imaging</td>
<td>16.00%</td>
<td>3.9%</td>
<td>72.7%</td>
<td>21.0%</td>
<td>2.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other tests</td>
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<td>3.1%</td>
<td>53.6%</td>
<td>39.3%</td>
<td>3.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Office visits - Est</td>
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<td>0.5%</td>
<td>42.8%</td>
<td>0.8%</td>
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<td>Rad Therapy</td>
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<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>ER</td>
<td>9.40%</td>
<td>1.8%</td>
<td>33.9%</td>
<td>0.0%</td>
<td>63.8%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other Drugs</td>
<td>8.40%</td>
<td>0.1%</td>
<td>63.1%</td>
<td>30.9%</td>
<td>5.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Lab Tests</td>
<td>8.10%</td>
<td>0.1%</td>
<td>62.5%</td>
<td>25.5%</td>
<td>11.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Spec - Ophthalm</td>
<td>7.10%</td>
<td>0.3%</td>
<td>93.7%</td>
<td>4.7%</td>
<td>1.3%</td>
<td>0.0%</td>
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<tr>
<td>Ambulance</td>
<td>4.10%</td>
<td>7.3%</td>
<td>19.5%</td>
<td>62.2%</td>
<td>11.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

IDENTIFYING RISKS

- What are the most common services provided in the clinics?
- Is there a change in pattern of coding?
- What is routinely received as denials for a particular service?
- Did the clinic or physician implement an EMR?
- Are clinic services routinely down-coded by Medicare or any other payer?
- How are units monitored prior to claim submission?
STRATEGIES FOR THE AUDIT PROGRAM

AUDIT PROGRAM DESIGN

- Define the need
- Establish your coding compliance goal / accuracy rate
- Prospective or retrospective
- Obtain policies and procedures for area of focus
- Choose an appropriate sample size
- Choose who should perform review
- Request data
AUDIT PROGRAM DESIGN (CONT.)

- Standardize a method for classifying and reporting variances
- Utilize credible references and determine audit tools to use
- Prepare the audit report with findings and recommendations
- Review with compliance committee and/or management
- Corrective Action Plan (CAP)
- Ongoing monitoring

DEFINE THE NEED

- Based identified concerns on reported activity
- Identified from monitoring
- Random or focused
- Document the audit objectives
- Define the reporting process of results
- How often will the audit be performed?
DEFINING THE NEED

[Graph showing data for different codes (99201 to 99205) across categories such as Physician, Family Practice Nat'l Avg., and Internal Medicine Nat'l Avg.]

DEFINING THE NEED

[Graph showing data for different codes (99211 to 99215) across categories such as Physician, Family Practice Nat'l Avg., and Internal Medicine Nat'l Avg.]
PRIMARY CARE USAGE OF MODIFIER 25

CONSIDER WHAT YOU ARE AUDITING:

- Chart / EMR
- Provider Selection
- Coder Selection
- Claim Submission
- Payment Received
ACCURACY RATE AND BENCHMARK

• A policy to define expectations from the physicians
• Define accuracy rate
• Determine what will be measured
  o Claims
  o Lines on the claim
  o CPT / ICD-9 / Modifier
• Define disciplinary or education

WHO PERFORMS?

• According the Office of Inspector General 's (OIG) auditing standards, evidence gathered by auditors and compliance officers should be sufficient, competent, and relevant.
  o Sufficiency
  o Competency
  o Relevancy
PROSPECTIVE VS. RETROSPECTIVE

- Prospective
  - Review of claims prior to being submitted for payment
  - May be performed internally or by outside consultants
- Retrospective
  - Review of claims after submittal for payment
  - May be performed internally or by outside consultants

AUDIT TOOLS

- Forms and templates--internally developed
- Purchase ready made tools
  - Customize the tool to your organization
- Data extraction software
- Consider data set for long term consistency and comparability
BEST PRACTICES FOR REPORTING
Corrective Action Plans & Who To Report To

REPORTING & FOLLOW-UP

• Draft report with stakeholders
• Final report with recommendations
• Follow-up on status of implementation of recommendations/corrective actions
• Identify monitoring activities for long term compliance
• Establish follow-up reporting timeframes
ERROR CALCULATION

- Count of met and not met for:
  - Claims
  - Lines (services billed)
- Net reimbursement
- Weighted points to the total lines
  - By line
  - Then subtotal
    - By type of CPT code
    - Diagnosis errors
    - Modifiers
    - Teaching physician count

ERROR RATE - CLAIMS

<table>
<thead>
<tr>
<th>Provider</th>
<th>Met</th>
<th>Not Met</th>
<th>Total</th>
<th>Accuracy %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>14</td>
<td>11</td>
<td>25</td>
<td>56%</td>
</tr>
<tr>
<td>B</td>
<td>14</td>
<td>11</td>
<td>25</td>
<td>56%</td>
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</table>
### PROVIDER A – WEIGHTED ACCURACY RATE

<table>
<thead>
<tr>
<th>Error Description</th>
<th>Error Point</th>
<th>Risk</th>
<th>Count by Line</th>
<th>Weighted Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line Met</td>
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<td>None</td>
<td>79</td>
<td>-</td>
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<tr>
<td>CC Missing</td>
<td>1.0</td>
<td>High</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No documentation</td>
<td>1.0</td>
<td>High</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M up coded 1 level</td>
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<td>14</td>
<td>3.50</td>
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<td>Medium</td>
<td>-</td>
<td>-</td>
</tr>
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<td>E/M up coded 3 levels</td>
<td>.50</td>
<td>Medium</td>
<td>-</td>
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<tr>
<td>E/M up coded 4 levels</td>
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<td>-</td>
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</tr>
<tr>
<td>E/M under coded 1 level</td>
<td>.25</td>
<td>Low</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M under coded 2 level</td>
<td>.50</td>
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<td>E/M under coded 3 levels</td>
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<td>Medium</td>
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<td>-</td>
</tr>
<tr>
<td>E/M under coded 4 levels</td>
<td>1.0</td>
<td>High</td>
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<td>-</td>
</tr>
<tr>
<td>No authentication</td>
<td>.10</td>
<td>Low</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Accuracy %** 96.01%

### PROVIDER B – WEIGHTED ACCURACY RATE

<table>
<thead>
<tr>
<th>Error Description</th>
<th>Error Point</th>
<th>Risk</th>
<th>Count by Line</th>
<th>Weighted Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line Met</td>
<td>0.0</td>
<td>None</td>
<td>70</td>
<td>-</td>
</tr>
<tr>
<td>CC Missing</td>
<td>1.0</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No documentation</td>
<td>1.0</td>
<td>High</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M up coded 1 level</td>
<td>.25</td>
<td>Low</td>
<td>6</td>
<td>1.50</td>
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<tr>
<td>E/M up coded 2 level</td>
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<td>Medium</td>
<td>5</td>
<td>2.50</td>
</tr>
<tr>
<td>E/M up coded 3 levels</td>
<td>.50</td>
<td>Medium</td>
<td>4</td>
<td>2.00</td>
</tr>
<tr>
<td>E/M up coded 4 levels</td>
<td>1.0</td>
<td>High</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td>E/M under coded 1 level</td>
<td>.25</td>
<td>Low</td>
<td>2</td>
<td>.50</td>
</tr>
<tr>
<td>E/M under coded 2 level</td>
<td>.50</td>
<td>Medium</td>
<td>2</td>
<td>1.00</td>
</tr>
<tr>
<td>E/M under coded 3 levels</td>
<td>.50</td>
<td>Medium</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M under coded 4 levels</td>
<td>1.0</td>
<td>High</td>
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</tr>
<tr>
<td>No authentication</td>
<td>.10</td>
<td>Low</td>
<td>2</td>
<td>.20</td>
</tr>
</tbody>
</table>

**Accuracy %** 88.62%
# CLAIM REVIEW RESULTS: DECEMBER 6, 20XX - DECEMBER 5, 20XX

<table>
<thead>
<tr>
<th>Federal Health Care Program Billed</th>
<th>Renal HCC #</th>
<th>Date of Service</th>
<th>Procedure Code Submitted</th>
<th>Procedure Code Reimbursed</th>
<th>Allowed Amount Reimbursed</th>
<th>Correct Procedure Code</th>
<th>Correct Allowed Amount</th>
<th>Dollar Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>3/40/XX</td>
<td>92214</td>
<td>92214</td>
<td>92214</td>
<td>$11.42</td>
<td>92214</td>
<td>$11.42</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicare</td>
<td>3/40/XX</td>
<td>92214</td>
<td>92214</td>
<td>92214</td>
<td>$11.42</td>
<td>92214</td>
<td>$11.42</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicare</td>
<td>3/40/XX</td>
<td>92214</td>
<td>92214</td>
<td>92214</td>
<td>$11.42</td>
<td>92214</td>
<td>$11.42</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicare</td>
<td>3/40/XX</td>
<td>92214</td>
<td>92214</td>
<td>92214</td>
<td>$11.42</td>
<td>92214</td>
<td>$11.42</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

| Medicare                          | 9/24/XX     | 99215          | 99215                    | 99215                     | $97.71                     | 99215                  | $97.71                | $0.00               |
| Medicare                          | 9/24/XX     | 99215          | 99215                    | 99215                     | $97.71                     | 99215                  | $97.71                | $0.00               |
| Medicare                          | 9/24/XX     | 99215          | 99215                    | 99215                     | $97.71                     | 99215                  | $97.71                | $0.00               |

Total: $12,351.40

0.44%

# AUDIT RESULTS – WORKING WITH PHYSICIANS
KEY TO SUCCESSFUL PHYSICIAN TRAINING

- Identify a physician champion
- Formulate and communicate a compliance message
- Encourage or require attendance
- The presenter can respond to questions and problems
- Ensure physician champion is a speaker

ACCOUNTABILITY

- Monitor expectations
- Reinforce expectations
- Positive tone
- Consequences if not a team member
- Compare results to expectations
LET’S TALK ABOUT EDUCATION VS. TRAINING

• E/M Lecture
• Case Studies
• Visual
• Kinetic
• Shadowing
• Face to Face on key issues with the MD denials
• Webinars
• Team education

REMEMBER

• Sign in sheets
• Evaluation forms
• Follow up survey of attendees
• Follow up on open items
• Identify if alternate methods preferred
ELECTRONIC MONITORING

MONITORING EXAMPLES

• Coding work queues
• Denial management
• Claim Scrubber
• Ethic/compliance hotlines
• Electronic monitoring reports related to work plan focus areas
  o Evaluation and Management coding distributions
  o Modifier usage
• Excluded Provider listing/Background checks
MONITORING EXAMPLES

• Teaching physician supervision requirements
• Evaluation and Management coding distributions
• Non-physician practitioner code use
• Clinical quality measures

CASE STUDIES
SAMPLE AUDIT PLAN FOR HIGH LEVEL E/M

**Purpose**
The purpose of this audit is to verify the use of high level E/M codes by one provider using time to assign E/M level.

**Scope**
Unless decided otherwise after initial research has been done, the audit will examine services billed for the provider in 2011. The charts will be examined solely for the purpose stated above.

**Other**
Place project under attorney client privilege.

SAMPLE AUDIT PLAN FOR HIGH LEVEL E/M

**Method**
1. Limit this audit to Medicare and Medicaid only.
2. Audit all claims including those not paid.
3. Assign a physician to complete a review of medical necessity.
4. Develop sample plan by analysis of data for services for the following:
   - Where 992X3 to 992X5 have been billed consecutively for greater than 2 months consecutively.
   - Scheduled time exceeds time allotted for E/M codes based on CPT coding guidelines.
SAMPLE AUDIT PLAN FOR HIGH LEVEL E/M

5. Design an audit tool including: the minimum necessary demographic information, date of service, place of service, provider, CPT, modifier, ICD-9-CM, findings (account for all possible errors).

6. Develop report of findings
   o Calculate line error percent
   o Include error percent based on net reimbursement
CHARGE CAPTURE - RISK

• New model with EMR
• Changes to coding
  o Modifiers
  o Automated
  o By coders or charge entry staff
• Ancillary systems
• Mismatch to EMR

CHARGE CAPTURE - AUDIT OR MONITOR

• Obtain edits for charge capture
• Review edits to written policy and procedure
• Compare the claim submitted to medical documentation
• Confirm to edits and on line comments
• Obtain data from ancillary system and practice management system
• Review edits to written policy and procedure
• Electronically compare the claim submitted to ancillary system
• Confirm to edits and on line comments
ELECTRONIC MEDICAL RECORDS

DOCUMENTATION RISKS
AHIMA AREAS OF CONCERN

• Authorship integrity risk
• Auditing integrity risk
• Documentation integrity risk
• Patient identification and demographic data risks

Guidelines for EHR Documentation to Prevent Fraud
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp
AUDIT - AUDITING INTEGRITY

- Determine EHR editing capability
  - Open versus closed records
  - Create test patient
  - Examine audit logs for audit trail
- EHR capability to use common date/time stamp across all components—test to determine if this can be manipulated in any way either in Epic or in the background.
  - Select one encounter and edit or add information
  - Test date and time stamp

CUT & PASTE OR COPY & PASTE

- Audit difficulty: identifying if this function was used
- Documentation integrity risk:
  - Bring forth information which is not specific to the patient
  - Fail to edit information that is not applicable to the subsequent encounter
- Utilized software originally designed to detect plagiarism at universities
- Using encounter data, compared the following EHR
  - Same provider, same primary diagnosis
  - All visits for one day for a provider

Plagiarism software download: http://plagiarism.phys.virginia.edu/
AHIMA article: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005520.hcsp
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